Avoid Malpractice & Protect Your License: Suicide Prevention is NOT Just for Patients!

Tracy L. Singh, RN, JD

When nurses talk about suicide, they are usually discussing their patients’ signs and symptoms of depression vs. suicidal ideations, how to care for suicidal patients, and what steps are needed to prevent suicide in the in-patient setting. Rarely, however, do we speak about the fact that nurses are human too, and they struggle with the same fears, self-doubt and insurmountable despair as our patients do.

Society tends to have negative opinions of those who commit suicide; questioning their motives, asking, “How could they be so selfish?” or believing there must have been “something wrong” with them to have done such a thing. Shame can often bring people to suicide, but suicide can also bring shame to those who are left behind. This general sense of disgrace creates an oppressive environment for those who are struggling, leading them into silence and isolation.

In healthcare, there can be an even stronger stigma against those with suicidal thoughts. Nurses are held to a higher standard. They are expected to know better, to use their critical thinking skills and to keep their personal problems to themselves. Simply put, nurses must be fit to work in the full scope of nursing at all times to avoid putting their patients at risk.

In many jurisdictions, people are placed closed without disciplinary action. While this is especially true when matters are awaiting their fate, nurses have reported experiencing migraines, panic attacks, gall bladder attacks, ulcers, PTSD, anxiety, sleeplessness, depression, feelings of betrayal, abandonment, loss of interest in nursing, and general hopelessness. Even when complaints are ultimately closed, nurses are often significantly impacted by the experience and some will have difficulty re-acclimating back into the nursing environment due to their sense of shame, lack of confidence and fears of further ridicule.

Nursing is not just a job; it’s a part of who we are. While nurses definitely need to learn all they can about caring for the suicidal patient, they should also be aware of the warning signs for themselves and their colleagues. We lost one of our own to suicide recently…she was a nurse for over 37 years when she was terminated and reported to the board. Within weeks, while the investigation was barely underway, she took her own life leaving her husband, children, grand-children and friends behind. This came as a shock to all who knew her and we can only hope that the tragic ending of her life can help save the lives of others.

If you or someone you know is struggling with thoughts of self-harm or suicide, please don’t hesitate to reach out for help. The Nevada State Board of Nursing accepts anonymous calls and there is a list of mental health providers available for nurses. My practice is dedicated to caring for those who care for others and our answering service is available 24/7 at (702) 444-5520. The suicide hotline is also available 24/7 at 1-877-885-4673.

Nurses matter too…please be kind to yourself and others.

If you or someone you know is in crisis, please call: 1-800-273-TALK (8255) suicidepreventionlifeline.org

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In 2013, the Centers for Disease Control and Prevention reported 41,149 people commit suicide the United States (US). Suicide was the 10th leading cause of death in 2013, with a suicide occurring approximately every 13 minutes. Suicide rates among the 15 to 24 age group was 11.1 per 100,000 population in 2013. In 2013, the State of Nevada had a suicide rate of 19.8% and ranked sixth in the US for the highest suicide rates. Prior to 2000, Nevada ranked number one in suicides for a decade. In 2015, suicide was the third leading cause of death among the 10–14 age group and second among the 15–34 age group.

Male suicide rates were four higher than females. Among ethnic groups (non-Hispanic white, non-Hispanic black, Hispanic, Asian or Pacific Islander (API), American Indian or Alaska Native (AIAN), AIAN had the highest suicide rate for both males and females (19.5 per 100,000 population), 1.5 times the national average. It is estimated that each suicide leaves at least six bereaved survivors. Consequently, over 245,000 persons are traumatically impacted yearly, and over 6 million Americans have been affected by suicide over the last 25 years.

The cost of suicide to society is significant. In 2010, the CDC estimated suicide at $44.6 billion per year in direct medical and work-related costs. Suicide is preventable. Most often, people need to know about the available resources that focus on suicide prevention as well as provide support to survivors. Given Nevada’s high ranking in suicide rates, suicide prevention education at the state and local level must increase and public awareness of the resources available for survivor support must be emphasized.

National Resources:
- National Suicide Prevention Lifeline – The 1-800-273-TALK (8255) hotline to speak with a trained counselor is available 24 hours per day, seven days per week. The website is: http://www.suicidepreventionlifeline.org.
- US Department of Health and Human Service – The Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services provides a toolkit for high schools consisting of suicide facts, prevention activities, screening tools, protocols to help at risk students, after-suicide tools, and staff education and training. The website is: http://www.samhsa.gov.
- Suicide Prevention Resource Center (SPRC) – SPRC is the only federally supported suicide resource center. It is funded under SAMHSA and is dedicated to the advancement of the National Strategy for Suicide Prevention through technical assistance, training, and materials to increase the knowledge and expertise among suicide prevention practitioners and other professionals managing people at risk for suicide. SPRC also collaborates with various organizations in developing the field of suicide prevention. The website is: http://www.sprc.org/.

Nevada Resources:
The Nevada Division of Public Behavioral Health, Office of Suicide Prevention has several useful resources. The website is: http://suicideprevention.nv.gov/Survivors/ Survivors.
- Suicide Prevention Training:

  - ASIST (Applied Suicide Intervention Skills Training) – ASIST is a two-day interactive course designed to familiarize caregivers with suicide risks, and assist them with recognizing warning signs, as well as facilitating interventions.
  - Nevada Gatekeeper Training Program – This program is designed to increase knowledge and understanding of suicide, including identifying warning signs, risk and protective factors, increasing willingness and ability to intervene with a person at risk for suicide, and identifying referral resources. Course length varies: 1 1/2 hours, 2 hours, 4 hours and 8 hours (Train the Trainer).
  - safeTALK—Suicide Alertness for Everyone – This is a 3-to 4-hour community alertness course to help participants recognize a person at risk for suicide and to ensure individual safety by providing resources to connect to a person trained in suicide first-aid interventions.

YMHA – Youth Mental Health First Aid – This 8-hour training for adults encourages peer-to-peer interactions between youth and adults. This course is suitable for youth-workers, athletic coaches, mentors, and juvenile justice professionals who interact regularly with youth.

- Publications – A list of suggested reading that support grieving, coping, and healing.

Survivor Support Groups

References:

Suicide Prevention and Support: A Look at Resources

Denise Rowe MSN, APRN, FNP, BC

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Suicidal behavior is complex, multifaceted, and linked to genetic, neurologic, psychological, social, and cultural factors (Kopacz et al., 2016).

Guilt has been linked to risk of suicide in veterans. In one study, close to 75% of veterans who had thought about suicide said they frequently experienced guilt about having violated the precepts of their faith groups, family, God, life, or the military (Kopacz et al., 2016).

Assessing for and addressing certain complex emotions, such as guilt and shame, is an important part of suicide prevention efforts. Guilt is defined as a “controllable psychological state that is typically linked to a specific action or behavior, which entails regret or remorse (Kopacz et al., 2016).”

In addressing and assessing guilt in veterans at risk of suicide, clinicians should try to recognize the source and clinical implications of this emotion. As with other negative emotions, the affective component of guilt is often the result of cognitive distortions made as the person tries to make sense of what has occurred or to reconcile beliefs of right and wrong with the guilt-inducing behavior. The common cognitive errors associated with guilt include:

- Hindsight bias (a belief that one should have known what was going to happen as a result of one’s actions)
- Responsibility distortion (a belief that one’s actions directly caused an adverse event)
- Justification distortion (a belief that one’s actions were not justified by the situation)
- Wrongdoing distortion (a belief that one violated one’s own standards of right and wrong) (Kopacz et al., 2016)

Cognitive therapy can counter the cognitive distortions that drive feelings of guilt. The goal is to guide patients to examine the evidence, process the event, and realize that their behavior was appropriate for the given situation (Kopacz et al., 2016).

Suicidal behavior is a major cause of morbidity and mortality in the United States, and reserve military personnel and veterans account for nearly 18% of suicide deaths. By one estimate, as many as 22 veterans die by suicide each day. These rates are thought to be due to a higher incidence of mental illness in certain veteran populations relative to the general population (Kopacz et al., 2016).

VHA has been progressive in addressing this very serious issue for the veteran population. The following are a few of the initiatives.

**VA National Initiatives**

- Research in suicide prevention
- Best practices in identification and treatment
- Educating employees at every level
- Partnering with community-based organizations and the armed forces
- Veterans Suicide Hotline/Chat Line

The National Veterans Suicide Prevention Hotline or Veterans Crisis Line has been a very effective tool that has helped veterans and their families who are dealing with this difficult challenge. The National Veterans Suicide Prevention Hotline was renamed the Veteran’s Crisis Line in 2011. This was to encourage not only Veterans but also, their families and friends to make the call. People who know a Veteran best may be the first to recognize emotional distress and reach out for support when issues reach a crisis point well before a Veteran is at risk of suicide.

No matter what problems you are dealing with, we want to help you find a reason to keep living. By calling 1-800-273-TALK (8255) you’ll be connected to a skilled, trained counselor at a crisis center in your area, anytime 24/7.
The suicide rate among military veterans is significantly higher than the rate in non-veterans. Statistics show that there are 17 veteran suicides a day (6205 a year) which accounts for 20% of all suicides in the U.S. (Veterans Support Organization, n.d.). Female military veterans commit suicide at six times the rate of other women. Suicide rates are usually expressed as the annual number of deaths per 100,000 people. The following table shows the rates found in a study of 173,969 suicides reported in the L.A. Times. (Zarembo, 2015)

<table>
<thead>
<tr>
<th>Group</th>
<th>Veterans</th>
<th>Non-Veterans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>32.1</td>
<td>20.9</td>
</tr>
<tr>
<td>Women</td>
<td>28.7</td>
<td>5.2</td>
</tr>
<tr>
<td>Men age 18-29</td>
<td>83.3</td>
<td>17.6</td>
</tr>
<tr>
<td>Women age 18-29</td>
<td>39.6</td>
<td>3.4</td>
</tr>
</tbody>
</table>

In the general population, women attempt suicide more often than men, but are less likely to be successful since they are more likely to use pills rather than a gun. Women veterans, however, are more likely to own a gun than are non-veterans. (Zarembo, 2015).

Some factors that probably influence the suicide rate are homelessness and substance abuse. About 33% of homeless in the U.S. are veterans (about 200,000 veterans) and 76% of them suffer from alcohol or drug abuse or mental health issues. PTSD is probably another factor and nearly 20% of veterans returning from Iraq and Afghanistan (about 300,000) have PTSD or major depression. (Veterans Support Organization, n.d.).

There are a number of resources available for veterans experiencing a crisis. All VA Medical Centers have a specially trained Suicide Prevention Coordinator as well as acute care and community-based services including mental health care. VA Outpatient Clinics provide many services including counselling. (Veterans Crisis Line, n.d.). There are VA Medical Centers in Las Vegas and Reno and community-based Outpatient Clinics in Elko, Ely, Fallon, Gardnerville, Las Vegas, and Pahrump. (U.S. Department of Veterans Affairs, n.d.). There is also a Veterans Crisis Line which promises an immediate response available at 1-800-273-8255 by pressing 1 after the answer. (U.S. Department of Veterans Affairs, 2016).

References
Increasing suicide rates in the U.S are an urgent public health concern; suicide is the 10th leading cause of death and accounts for more lives lost than traffic accidents and homicides. In the state of Nevada, suicide is the 6th leading cause of death overall and the 2nd leading cause of death for our youth and young adults ages 10-34. Up to 45% of people who die by suicide had contact with their primary care provider (PCP) in the month prior to their death. Nurses make up a large portion of healthcare professionals in this country and most likely see patients who are considering suicide. Because of the unique relationship nurses have with patients, our part in assessing and screening of patients with suicide ideation is imperative.


In summary, the Joint Commission’s aim is to assist healthcare organizations, both inpatient and outpatient, to better screen and identify, then treat and provide follow-up care to individuals with suicide ideation. The focus of the Sentinel Event Alert was on healthcare workers in the emergency, primary, and behavioral health areas, both inpatient and outpatient, and actions that could be taken to ensure workers are being trained to assess and care for patients who are at risk for suicide.

The following recommendations were brought forward by the Joint Commission on detecting and treating patients at risk for suicide.

A. Detecting suicide ideation in non-acute and acute care settings
   1. Review patient and family history of suicide risk factors
   2. Screen all patients using a brief, evidence-based tool
   3. Review the screening tool prior to the patient leaving the appointment, clinic or hospital

B. Taking immediate action and safety planning
   4. Take action based on assessment results in order to inform level of safety measures needed and provided

C. Behavioral health treatment and discharge
   5. Establish collaborative and ongoing care
   6. Improve outcomes for at-risk patients

D. Education and documentation
   7. Educate all staff in assessing for suicide ideation
   8. Document decisions regarding care

Nurses are directly impacted by patients with suicide ideation. We are often the first healthcare professionals patients see. We are with patients in acute care settings 24 hours a day, and in non-acute settings we often see patients more regularly or have more contact with them than other healthcare professionals. While this is never...
an easy subject to broach with our patients, the nature of what we do as professionals allow us to be well-positioned to meet the recommendations of the Joint Commission.

The most common evidenced-based tool for suicide ideation, the PHQ-9 (Patient Health Questionnaire 9), has been used successfully to screen for Depression. This 9 item self-administered questionnaire asks about symptoms of depression but also contains a question specifically about suicide; “thoughts that you would be better off dead or wanting to hurt yourself in some way.” The questionnaire is available in the public domain at www.phqscreeners.com/sites/g/files/g10016261/f/201412/PHQ-9_English.pdf.

Here are risk factors for suicide:

• Previous suicide attempt(s)
• History of depression or other mental illness
• Alcohol or drug abuse
• Family history of suicide or violence
• Physical illness
• Feeling alone

Here are specific ways nurses can take action to raise awareness of suicide and help in decreasing rates of suicide.

• Advocate for systems in your healthcare setting to support nurses in assessing and responding to patients with suicide ideation.
• Advocate for training on use of evidence-based screening tools to assess for suicide ideation.
• Become familiar with organizational, agency, and area resources in place to assist the patient with suicide ideation.
• Universally screen for depression
• Aggressively treat depression.
• Screen patients with key risk factors for suicide.
• Educate patients on warning signs for suicide.
• Educate patients and caregivers on reducing access to lethal means.
• Refer patients to the National Suicide Prevention Lifeline: 1-800-273-TALK (8255)

Finally, nurses need to know about resources available for patients with suicide ideation.

References

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